Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/SOIA

PRIOR AUTHORIZATION SPELL OF ILLNESS ATTACHMENT

(Physical, Occupational, Speech Therapy)

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

(1) LAST NAME	(2) FIRST NAME	(3) MIDDLE INITIAL	(4) MEDICAL ASSISTANCE ID NUMBER	(5) AGE
RECIPIENT	IM	A	1234567890	19

PROVIDER INFORMATION

(6) THERAPIST'S NAME AND CREDENTIALS	(7) THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER	(8) THERAPIST'S TELEPHONE NUMBER
I.M. PERFORMING, O.T.R.	87654321	(XXX) XXX - XXXX

(9) REFERRING/PRESCRIBING PHYSICIAN'S NAME: I.M. REFERRING

A. ☐ Physical Therapy SOI ☒ Occupational Therapy SOI ☐ Speech Therapy SOI

B. Provide a description of the recipient's diagnosis and problems.
Indicate the functional regression which has occurred and the potential to reachieve the previous skill.

Client received the diagnosis of Rheumatoid Spondylitis at age 16. His condition has been progressive with involvement of both upper extremities at this time. Discharge from nursing home to his own adapted apartment with minimal help from his family is planned once his condition stabilizes. A program of range of motion, gentle stretch, gradual strengthening and activities of daily living for personal needs and adapted homemaking are possible with this intelligent, well motivated young man.

C. Attach a copy of the recipient's Therapy Plan of Care, including a current evaluation.

D. What is the anticipated end date of the spell of illness. MM/DD/YY

E. Supply the physician's dated signature on either the Therapy Plan of Care or the Physician's Order Sheet.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

F. I. M. Prescribing — Signature of Prescribing Physician (A copy of the Physician's Order Sheet is acceptable) — MM/DD/YY Date

G. I. M. Performing — Signature of Therapist Providing Treatment Providing Evaluation/Treatment — MM/DD/YY Date